State of Hawaii
Department of Health/Child & Adolescent Mental Health Division
Department of Education/School-Based Behavioral Health

CROSS-SYSTEMS TRAINING
Registration Form

Training _____
Date _____
Location _____

PLEASE NOTE:
Effective immediately, DOH/CAMHD will use the web as the primary means of notifying DOH, DOE, DHS, Providers and Families about the Cross-Systems Training Schedule. For updates to this schedule, including cancellation of classes and changes in class dates, times and locations, please check the following web site, especially the day before the training: www.state.hi.us/doh/felix/dev.html

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Name _____ _____
First **Last**

Agency or School _____

School District _____ **Agency/School City** _____

Job Title _____

Phone_____ **Fax**_____ **Email** _____

Please fill out the following information to help us ensure that the training can meet your level of experience and expectations.

Education: ❑ **Bachelors** ❑ **Masters** ❑ **Doctoral** ❑ **Other :** _____

Professional License: ❑ **Yes** **In the area of** _____ ❑ **No**

On a scale of 1 – 10 (1 = low; 10 = excellent), please rate the following:

Quality **of your formal training in working effectively with children/adolescents:** _____

Quality **of your work experience (post education) in working effectively with children/adolescents:** _____

How many years have you worked with children/adolescent with emotional and/or behavioral disabilities? _____

REGISTRATION DEADLINE: ***TEN (10) WORKING DAYS*** **prior to the scheduled training**
FAX OR EMAIL COMPLETED FORM TO:
Rowan Tokunaga (Fax # 733-9875 rstokuna@camhmis.health.state.hi.us Ph #733-9273)

PLEASE NOTE: Training dates are subject to change, depending on the number registered.
You will be notified *only* if we are unable to register you for your requested training.
Please check the web site listed above for changes in classes and cancelled classes.
If you will not be able to attend, please provide notice at least 24 hours prior to the training date.